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ABSTRACT

In spite of statistics that show that demographically there are increasingly more women than men as people age, and that epidemiologically women are more likely than men to utilize health services, most health services continue to be based on research and training that is both age and gender biased. Few mental health professionals are knowledgeable about gender differences in development and/or late life developmental and aging processes. Therapists who are not trained in late life development, in the normal processes of aging, or in the special needs of the older adult tend to rely on personal experience with older people, both positive and negative, to guide them in relating to geriatric clients. The goal of counseling psychologists should be to serve the needs of older women by depathologizing the normal processes of late life development and aging and by respecting the differences in women's ways of knowing and relating to others. In addition to training in life span development and in gender differences, psychologists must work through issues with aging, so that the pitfalls of countertransference in working with older women are avoided. Although therapy processes with older women are often different, the potential for healing and growth for older clients and their families can be just as exciting and rewarding to the counselor as is working with clients of any age. Four case examples are provided which demonstrate the strong relational bonds, some countertransference issues, and the benefit of life review processing found in therapeutic sessions with older women. (ABL)

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WHAT'S SPECIAL ABOUT COUNSELING OLDER WOMEN?

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What's Special About Counseling Older Women

This paper on counseling older women is not meant to exclude the issues of older men, but rather to emphasize **the feminization of geriatric mental health**, and to call attention to some special issues for women in late life that are often not recognized.

In spite of statistics that show that, demographically, there are increasingly more women than men as people age and, epidemiologically, women are more likely than men to utilize health services (Wingard, 1984), most health services continue to be based on research and training that is both age and gender biased (Travis, 1988).

The older woman who seeks mental health services may well be warned that **"counseling could be hazardous to her health!"** because few mental health professionals are knowledgeable about gender differences in development and/or about late life developmental and aging processes. This lack of training places the older woman client in **double jeopardy** of being misdiagnosed and of being written off as hopeless. Such ignorance promotes the prevalent use of damaging diagnostic labels for women as "co-dependent", "psychosomatic", "hysterical", "passive-aggressive" and "dependent personality". Therapists who are not trained in late life development, in the normal processes of aging, or in the special needs of the older adult tend to rely on personal experience with older people, both positive and negative, to guide them in relating to geriatric clients. This creates a situation ripe with countertransference issues for the therapist.

Counseling psychologists rely heavily on various developmental theories as guides to work with "normal" populations, experiencing "common" problems of daily living. Yet, few developmental theories have recognized that there is continuing growth potential past the middle years or even past adolescense and, traditionally, developmental theorists have held male patterns of development to be superior to female patterns (Belenky et al, 1986; Gilligan, 1982; Miller, 1976)

For mental health professionals who have had training and/or specialized interest in gerontology and geriatrics, much of their knowledge about aging has come from research done primarily on older men (see Hess, 1990). It is only recently that gender differences in development and health have been studied in valid, non-biased ways and the study of late life gender differences remains fertile ground for research.

Gender Differences in Development

Feminist scholars like Jean Baker Miller (1976) and her colleagues at Wellesley, along with Carol Gilligan (1982) at Harvard, have brought new perspectives on gender differences in both social and cognitive development. They argue that unlike the normal pattern of individuation, separation, and independent, autonomous development for males, women typically form their identities through connected, relational, interdependent patterns of development; and secondly that, unlike the linear, cause and effect, legalistic thinking patterns that males exhibit in

problem-solving, women typically process information systemically, contextually, and relationally.

Before the feminist movement in psychology, the typical male patterns of development went unchallenged as the "normal and healthy" way to think and behave, while the typical female patterns of development have been generally accepted as "immature and inferior" ways of thinking and being. As a result, this "Self-in-Relation" model of identity formation (as described by Miller, 1976) may be incorrectly diagnosed as dependent (or more recently, co-dependent). Further, when women look contextually at a problem and consider many alternatives, this might be viewed as ambiguity or resistance by the uninformed counselor.

Feminist mental health professionals renounce such historical, traditional views, and believe that both male and female patterns of development are normal and valid. It is the extreme cases in either independent or dependent behavior that is disordered, and the extreme rigidity or the extreme indecisiveness in thinking patterns that are dysfunctional.

Late Life Development and the Normal Processes of Aging

Bernice Neugarten at the University of Chicago and her colleagues have studied life span development for many decades. Neugarten has departed from her earlier concepts of "age-graded roles" and "stage" theory (Neugarten & Hagestad, 1976) to call for "need-based" theories to drive the policies and services of an "age-irrelevant society" (Neugarten, 1979).

Barring organic disease, cognitive impairment, and physical disability, there are very few differences that can consistently be demonstrated between the well elderly and younger age groups. One apparent change however, is the slowing down of cognitive processing, so that it takes an older person longer to sift through new information to understand and accept that which has meaning for him or her. Along with this phenomenon, Neugarten (1977) notes an increase in what she terms as "interiority", a deeper internalization of information, a musing and measuring of new material to see how it fits with all the past experiences. Butler (1974) refers to this as "life review" processing. These factors can dramatically affect the interactions between the counselor and the client.

Countertransference Issues

Communication patterns are altered as a result of cognitive slowing and increased interiority. The pace and the process of therapy with an older client will often be different than with younger clients as a result. For counselors, who pride themselves on communication abilities and who find satisfaction in being present during the cathartic, insightful, "aha" experiences of their clients, the older client may seem slow, dull, tedious, and unrewarding to work with. While the older client is more slowly processing information and often at a much deeper level than younger clients, the counselor who relies on the usual cues may think that the client is not hearing, is not attending, or is not understanding during a session, when

actually much is going on for the client internally and may culminate in significant insight hours or days or even weeks after the therapy session is over. Such misguided perceptions and unmet needs of the counselors, may lead to inaccurate assessments of depression, resistance, senility, or low intelligence of the older client. In addition to misdiagnoses, the counselor's countertranference issues may lead to patronization, ineffective treatment, or premature termination of a client who is quite capable of making important significant life changes.

Furthermore, if this older client happens to be female, whose identity has been formed and whose sense of herself is powerfully centered in her relationships to others, the counselor may become frustrated at her slowness to act autonomously or assertively, or to "take care of herself", particularly around caregiving roles with others. Such counselor frustration may also lead to premature termination of treatment, either from the counselor's hopelessness or from the older woman's fear of the pressure on her to change.

Case Examples

To illustrate these dynamics, I have selected four case examples which demonstrate the strong relational bonds, some countertransference issues, and the benefit of life review processing in women that I have known.

Amy

Amy was referred to me by her physician, with suicidal ideation and great emotional distress over abuse she had suffered

as a child, more than 60 years ago. This client had a long history of physical illness but no history of mental disorder and had never been in counseling before. She had had two heart surgeries and was currently taking 13 different prescribed medications, so her history with this referring physician was long and intense. Though he was a family practitioner, he was interested in psychology, was in therapy himself and fancied himself to be therapeutic with his patients. He would encourage her to talk about her problems, then would become overwhelmed by her distress and would resort to the treatment that he knew best, medication. She trusted him implicitly and had come to counseling only because he insisted she should give it a try.

In our first meeting, I asked her to bring all her medications with her so that I could understand more about the affects these may be having on her emotions. I discovered that she had been prescribed, and was taking, a tranquilizer and an antidepressant for many years, and in the past few weeks had begun taking Xanax, a powerful antianxiety medication. When I contacted her physician, I realized that he had forgotton that he had prescribed the Xanax and that he considered the neurological symptoms that I was observing as "hysterical reactions". At my suggestion, he agreed that she might want to discontinue taking the Xanax but beyond that I had difficulty in getting cooperation in mutual treatment of this very troubled, chronically ill woman.

My professional assessment was that my client's relationship with this physician was not in her best interests and my personal frustration in trying to deal with him made me want to refer her to another physician who would be easier for me to work with. I knew however, that to do so would, undoubtedly, end in her leaving therapy rather than in her leaving her physician. Although she was benefiting from her therapy and was slowly establishing a relationship of trust with me, this other relationship was more powerful and if I wanted to help her, I had to honor that. Over several months, I found gentle ways to query aspects of her medical treatment and to guide her in her interactions with her physician.

After about nine months into her therapy and much progress, Amy regressed and became quite distraught once more. Her physician, without consulting me, announced to her that he was going to admit her to an inpatient group for incest victims, which in my opinion was both inappropriate and anti-therapeutic for her. At that point she sought my recommendation and concluded, "I've decided that you are my "head doctor" and he can take care of the rest of my body". With that relational shift, she was better able to question and assert herself in her health care and progressed steadily after that.

Had I overtly challenged her physician or had I pushed her to stand up to him before her relationship to me was firmly established, I am sure that she would have left therapy, would

have been hospitalized, and would have become even more dependent on a negligent physician.

Betty

Several years ago, I learned of a case in which the psychologist was caught in an ethical dilemma about the treatment of an older woman. Betty, who had been clinically depressed for many, many years, had been treated by numerous other therapists with varying degrees of success. Her usual pattern was to seek treatment when she was suicidal and desparate. As soon as she started feeling better, she would terminate treatment but never fully recover from her depression.

With this new therapist, she made her typical progress, but soon began reporting problems with her marriage. Her husband refused to be involved in marital therapy, saying that her depression was her problem and had nothing to do with him. Betty regressed and the therapist felt frustrated and blocked. After several months of no progress, he told her that he did not know how to proceed; that if she did not come up with some goals to work on in therapy, he felt that they must terminate treatment. She returned the following week with a very clear goal, "to maintain an optimal level of depression", so that she did not feel so desparate and suicidal, but also so that she did not change so much that it threatened her marriage to her husband.

The therapist was truly caught in a bind. He had insisted on a goal, but the client's goal antithetical to his perceived professional responsibility. To the client, the goal made

perfect sense and was actually what she had been doing on her own for years. Her sense of herself in relationship to her husband required her to be somewhat depressed. Her sense of herself in relation to her therapist required her to recover from her depression. Each time she had been in treatment these two relationships sooner or later came into conflict. At the point where this conflict emerged, the marital relationship prevailed and the therapeutic relationship was terminated.

Luckily, this therapist agreed to work on this unorthodox goal with her and the therapeutic relationship was not sacrificed. With this difference, the client found a new sense of control in the relationship with her therapist and eventually was able to transfer some of this experience to her marital relationship and finally to give up her depression.

Had this therapist not been willing to stretch his own beliefs and thinking to accomodate this woman's relational needs, his client might never had been able to overcome her depression.

Cindy

Avoiding countertransference pitfalls with older women clients is difficult. In this next case, it was not a client, but a student that I encountered problems. Last Spring, in a course entitled, "Counseling the Older Adult", I had an 80 year old student. Cindy had just completed her bachelor's degree and was beginning work on a masters degree in gerontology. She was an intelligent, small, white haired grandmother, who had suffered many hardships in life, and who worked diligently to be pleasing

to everyone, students and professors alike. Of course the media loved her and she had become somewhat of a celebrity around campus.

With most of her other professors, she had either been ignored and tolerated as superfluous, or she had received patronizingly special treatment because of her age. I was impressed with her determination to pursue an education and with her use of coursework to cope with depression resulting from some very tragic losses in her life. It would have been easy to have let her slide through in my class, patronizing her as others had done, but I knew that was ageist and not fair to her or to my other students. I certainly did not want to model patronization of sweet little old ladies to students who were learning about counseling older people.

I struggled the whole semester, in balancing my own countertransference issues toward deferiential treatment. She struggled as well, in her desires to be one of the group, but also in using her age as protection, as manipulation, and as a defense. We had many conferences and several mild confrontations around such issues as her addressing me as "honey", around her hearing impairment (which interfered with her learning but which she refused to have treated), around the assignments (which were designed as practical experiences for beginning mental health professionals but which she saw as impolite, intrusions on privacy of others and unimportant for her to do as she was "too old" to ever be a practitioner anyway). At times she felt that I

was not treating her like the other students, but when I did, she worried that she was not measuring up and that she would fail. She would sometimes, jokingly, accuse me of picking on her. At one point, she openly challenged me during class about what she considered to be unfair treatment. She was angry and the whole class could see this. Although I disagreed that I was treating her unfairly, I viewed her standing up for herself as a very positive, risk-taking, assertive behavior and I told her so. This outburst caused her much anxiety because she had never before in her life challenged an authority figure and risked being unpopular and not liked. The next day she came to me to apologize, extremely worried that I might fail her. I explained to her that if I did fail her, she should appeal her grade because she had successfully completed all assignments and deserved high marks for her performance. For the first time, she looked at me with fire and spirit in her eyes and said, "I would, too!"

By the end of the semester, we had both learned much and had developed a relationship based on a high regard for each other as competent women rather than on superficial, polite, "respect" for age and position. She had experienced herself as an intelligent, assertive woman, capable of holding her own in a class with younger people, rather than feeling like the "cute little old lady in college". She stated that she did not worry about an afterlife because she felt as though she were "in heaven" now, fulfilling her lifelong dream of achieving an education. Her

parting words to me were, "You are the strangest professor I have ever known". I took this as a testimony to my success.

While this is an extreme example of a non-traditional student, I think it represents many of the issues for mid-life and older women who are returning to educational pursuits.

Doris

As a final example of the mental health needs of an older woman, I want to briefly describe the experience of a new friend of mine. I met her earlier this summer, in a week long retreat, designed to review, evaluate and effect desired changes in one's lifecycle. Doris is a 70 year old, recently widowed woman, who describes herself as liberal, an old socialist, and an active feminist. She had come to the retreat to resolve some old anger toward her older sister. She was lonely since the death of her husband and her sister was failing in health. If she could get along better with her sister she could invite her to come live in her big empty apartment and could close out these final years of her life feeling content and enjoying the companionship.

All the other 19 group members were 20 to 50 years younger than Doris. At times during the very intense week of group work, she looked like she was asleep. She rarely said much, but always responded when others asked for her opinions, comments, or advice. Everyone was interested in what she had to say and often sought her out, as she proved to be very direct, wise and succinct in her responses. She was present at all sessions but did not "overtly" participate in this very active therapy group.

I had the advantage of getting to know her much better than the others as we were assigned as roommates.

By the end of the week she disclosed to me that the anger toward her sister did not seem to be such a significant thing to her anymore and that the greatest benefit she had received from this week-long experience was a strong sense of validation from the acceptance by the other members of the group. I was probably the only one who knew the deep internal processing she was doing in her silent reveries throughout the group experience.

Since that week she has returned to her empty apartment and has begun entertaining friends and going out much more than she had before. She has begun a new life as a single woman, which is exciting but very frightening for her, as she was devoted to her husband and had derived much of her sense of herself from her relationship to him. The outcome has been for her to change and grow in new risky ways rather than to settle into old age acceptance and contentment.

Conclusion

As counseling psychologists, it should be our goal to serve the needs of older women by depathologizing the normal processes of late life development and aging and by respecting the differences in women's ways of knowing and relating to others. In addition to training in life span development and in gender differences, we must work through our own issues with aging, so that we avoid the pitfalls of countertransference in working with older women. Although therapy processes with older women are

often different, the potential for healing and the growth for older clients and their families can be just as exciting and rewarding to the counselor as is working with clients of any age.

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